



Commonwealth of Massachusetts Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Dental and Vision Enrollment and Change Form (FORM -1)
FOR MANAGERS, CONFIDENTIAL EMPLOYEES, THE LEGISLATURE, CONSTITUTIONAL OFFICES AND THEIR STAFF ONLY. EMPLOYEES SUBJECT TO COLLECTIVE BARGAINING AND EMPLOYEES IN HIGHER EDUCATION, THE JUDICIAL COURT SYSTEM, MUNICIPALITIES AND AUTHORITIES ARE NOT ELIGIBLE.
PLEASE PRINT CLEARLY

01 ☐

Insured's GIC-ID (usually Soc. Sec. #) ____		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth ____/____/____	Dept. ID # or Agency/Division # ____/____
Name - Last ____		First ____		MI ____
Address: (Number and Street) _____ This is a new Address <input type="checkbox"/>				
City ____		State ____	Zip Code ____	Employee ID (HR/CMS agencies only) ____
Date Entered Service: ____/____/____		Home Phone: (____) _____		Work Phone: (____) _____

02 ☐ **NEW ENROLLMENT** ☐ **PROMOTION** ☐ **CHANGE** ☐ **CANCEL COVERAGE** ☐

EFFECTIVE DATE ____/____/____	Dental Benefit (Please check One) <input type="checkbox"/> Indemnity Plan (Classic) <input type="checkbox"/> PPO Plan (Value)	Vision Benefit (Select Provider at Time of Service)
Type of Coverage Individual <input type="checkbox"/> Family <input type="checkbox"/>	I understand that I may not change this plan type until the next annual enrollment period.	

SPOUSE/DEPENDENT INFORMATION

CHECK ONE: ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

List below all family members, including your spouse, who will be covered under your dental and vision family plan. Attach a separate sheet if additional space is required. Please provide all Social Security Numbers (required under Federal Law Section 111) and exact dates of birth for each dependent. To add a dependent age 19 to 26, you must complete and return to the GIC a Dependent Ages 19 to 26 Enrollment Application. **Important:** The Group Insurance Commission requires you to provide a copy of a marriage certificate, birth certificate, certificate of appointment as legal guardian, etc., for each person you list as a dependent.

Last Name	First	M.I.	Relationship	Date of Birth	Sex	Social Security Number (Required)
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Reason for addition or deletion: _____ Effective Date: _____

03 ☐ **Name Change**

Previous Name: _____

New Name: _____

LEAVE OF ABSENCE

GIC USE ONLY: Effective Date: ____/01/____ Leave Pay Status: ☐ Part ☐ Full

04 ☐ **Leave Is:** ☐ With Pay ☐ Without Pay

Leave Type (You MUST Check one of the following):

<input type="checkbox"/> Educational	<input type="checkbox"/> Family (for dep < age 3)	<input type="checkbox"/> Maternity*	<input type="checkbox"/> Personal Illness*	<input type="checkbox"/> Sabbatical	<input type="checkbox"/> FMLA
<input type="checkbox"/> Family (for dep > age 3)	<input type="checkbox"/> Industrial Accident*	<input type="checkbox"/> Military	<input type="checkbox"/> Personal Reason	<input type="checkbox"/> Suspension	<input type="checkbox"/> Other

*Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.

Duration of Leave: Start Date: ____/____/____ End Date: ____/____/____ Last Day on Payroll: ____/____/____

05 ☐ **Return to Payroll Deduction:** First Day Back in Payroll: ____/____/____

INSURED CHANGES

06 ☐ **Retirement** Date Retired ____/____/____

07 ☐ **Transfer to another Agency** Name of Agency Transferred to _____ Effective Date ____/____/____

08 ☐ **Transfer from another Agency** Previous Agency _____ Effective Date ____/____/____

09 ☐ **Termination Coverage** Termination Reason _____ Termination Date ____/____/____
(if elected) ☐ COBRA (must complete COBRA Dental application)

PLEASE READ CAREFULLY

Eligibility: I understand that only managers, confidential employees, the legislature, constitutional offices and their staff are eligible for this program. I am an employee that falls into one of these categories and I am not employed by higher education, the judicial court system, a municipality, and/or an authority.

Deduction Authorization: I authorize my employer to deduct from my payroll check the amount required for the dental and vision coverage I have selected.

Dental Plan: I understand that when I choose a dental plan, I cannot change plans until the next annual enrollment, even if my dentist leaves the plan.

x _____ Signature of Applicant	_____ Date	x _____ Signature of Authorized Official	_____ Date
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**FOR GIC
USE ONLY**

ENTERED

VERIFIED

POLITICAL SUBDIVISION

RETURN COMPLETED FORM TO YOUR GIC COORDINATOR

DENT/VISION 3/12